Acknowledgment of Medicaid Criteria on Abortions

Date_____

Name of Medicaid Provider _____

Medicaid Provider Number _____

I hereby certify that funds received from the Department are not used to pay or otherwise reimburse, either directly or indirectly, any person agency, or facility for the performance of any induced abortion services unless:

(a) in the professional judgement of the pregnant woman's attending physician, the abortion is necessary to save the pregnant woman's life;

(b) the pregnancy is the result of rape or incest reported to law enforcement agencies, unless the woman was unable to report the crime for physical reasons or fear of retaliation; or

(c) in the professional judgement of the pregnant woman's attending physician, the abortion is necessary to prevent permanent, irreparable and grave damage to a major bodily function of the pregnant woman provided that a caesarian procedure or other medical procedure that could also save the life of the child is not a viable option.

I further certify that records to support the certification will be retained and made available to the Department on request consistent with participation as a Medicaid provider.

This certification shall be ongoing and apply to all future claims unless the provider notifies the Department in writing of a change in certification status

Completion of this form is required of physicians performing induced abortion procedures. A copy of this form will be kept on file in Medicaid Operations.

_____

Signature

Title:_____